MISSOURI DEPARTMENT OF REVENUE
CUSTOMER ASSISTANCE BUREAU
P.O. BOX 200
JEFFERSON CITY, MO 65105-0200
TELEPHONE: (573) 751-2730
FAX: (573) 522-8174

DRIVER CONDITION REPORT

FORM **4319** (REV 4-01)

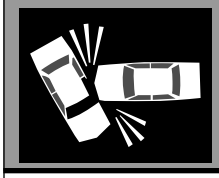
Please complete the Driver Condition Report if you have personal knowledge about a driver you believe is no longer able to safely operate a motor vehicle.

- You should report only your firsthand knowledge of the driver.
- You should complete the entire form and sign your name on the reverse side.
- After reviewing this report, the director of revenue may require the driver to take certain tests such as a medical, vision or driving test.
- All information contained in this report shall be kept confidential, unless released by a court order.

PERSONAL INFORMATION ON PERSON BEING REPORTED: **Please complete all available information.**	NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER OR DRIVER LICENSE NUMBER	
	LICENSE PLATE NUMBER	STATE OF ISSUANCE	DATE OF BIRTH	TELEPHONE NUMBER ( )
	ADDRESS		CITY	STATE / ZIP CODE

Describe in detail incidents or conditions about this driver. Give specific information such as dates, places, accident reports and all other available information to support the need for re-examination. You should report only information of which you have personal knowledge or physical evidence. Do not report what you have been told or heard.

DRIVER BEHAVIOR



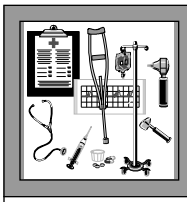
Please check appropriate boxes based on personal knowledge of incident if applicable. Please give a detailed description of incident. Age alone is not a sufficient reason for retesting.

- ☐ Traffic Violations
- ☐ Lack of Attention
- ☐ Dangerous Actions
- ☐ Caused Traffic Accident/Incident
- ☐ Poor Driving Skills

LOCATION

DATE | TIME

- ☐ Lack of Knowledge of Traffic Laws
- ☐ Obstructing Traffic
- ☐ Other



MEDICAL CONDITIONS

Please check ✓ appropriate boxes if the driver being reported has any of the following conditions that would impair his or her ability to safely operate a motor vehicle:

☐ **COGNITIVE IMPAIRMENTS/PSYCHIATRIC DISORDER**
(i.e., sees or hears things that are not there, gets lost easily, has problems remembering words for common things, confusion in thought process or judgment)

Please explain: _____

☐ **VISUAL IMPAIRMENT**
(frequently runs into objects, cannot see road signs, cannot see objects on the side without turning head)

Please explain: _____

☐ **ALCOHOL/DRUG ABUSE**

Please explain: _____

☐ **DISORDERS THAT IMPAIR CONSCIOUSNESS**
(i.e., seizures, blackouts, sleep disorders)

When was the last loss of consciousness?

_____ (month) / _____ (day) / _____ (year)

Please explain: _____

☐ **LIMITED MOBILITY**
(i.e., paralysis, problems moving freely)

Please explain: _____

☐ **OTHER CONDITIONS**

Please explain: _____

ADDITIONAL COMMENTS

Please attach additional comments if necessary.

PERSON COMPLETING FORM:

ANY PERSON WHO INTENTIONALLY FILES A FALSE REPORT SHALL BE GUILTY OF A CLASS A MISDEMEANOR, AND SHALL BE LIABLE FOR THE DAMAGES WHICH RESULT.

PRINT FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO DRIVER		TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE			DATE

MO 860-2507 (4-01)